

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6015
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Ma</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (If this place) <u>Week</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Annapolis</u>		OR TOWN <u>Salisbury</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Princess Anne Hospital</u>				STREET ADDRESS (If rural, give location) <u>Hotel St.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>James</u>		(Middle) <u>Burns</u>		(Last) <u>Burns</u>	
4. DATE OF DEATH		(Month) <u>June</u>		(Day) <u>10</u>		(Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>6-2-1909</u>	9. AGE last birthday: <u>46</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Sawmill</u>		11. BIRTHPLACE (State or foreign country): <u>Ma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Frederick Burns</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ballard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>218-12-1206</u>		17. INFORMANT & ADDRESS: <u>Orlando Burns, Princess Anne, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
823X Immediate cause <u>Fracture of knee</u>							
Antecedent cause(s) <u>Due to automobile collision with car</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last <u>Alcohol</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>On road near Annapolis, Md.</u>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>June 4, 1955 1:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>M. E. Santorini</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6/11/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>G. H. H. H.</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>6-15-55</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State): <u>West Post Office, Somerset, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-15-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR: <u>J. F. STEWART FUNERAL HOME</u> ADDRESS: <u>Salisbury, Md.</u>			

BUREAU V. S.

JUN 17 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6016

CERTIFICATE OF DEATH

06024

Dr. Gilmore & Ellis

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR end give nearest town) Hebron Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Hebron			
TOWN Hebron				STREET ADDRESS (If rural give location) R.D. # 1			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital							
3. NAME OF DECEASED (First) CARRIE (Middle) TURNER (Last) BROWN				4. DATE OF DEATH (Month) June (Day) 30 (Year) 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 18, 1914		9. AGE last birthday 40 yrs.	IF UNDER 1 YEAR (Month) 11 (Day) 12 (Hours) 12 (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work -Sales Clerk(J.C.Penny Co.)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bivalve Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Anderson				14. MOTHER'S MAIDEN NAME Ella Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Carlton J. Brown(Husband) R.D. # 1 Hebron, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
200.0 IMMEDIATE CAUSE (A) Reticulum cell Sarcoma						3 months	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.							
SIGNATURE William R. Ellis, Jr. M.D.				ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland			
DATE SIGNED July 7, 1955							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 3, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) Salisbury, Maryland	
24. REC'D BY REGISTRAR 301 5 1955		REGISTRAR'S SIGNATURE Mary Dr. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			
DATE							

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BUFILE V. S.

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July 8, 1945 Wisconsin Historical Survey

500



6017

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Accomac</u>		MARYLAND		STATE <u>Virginia</u> COUNTY <u>Accomac</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>				TOWN <u>Bloxom</u>		83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Pennine General Hospital</u>							
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First)		(Middle)		(Last)			
Lola		G		Brown			
(Type or Print)				DEATH		June 23 - 1953	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White				1881	
						9. AGE last birthday	
						74 yrs.	
						IF UNDER 1 YEAR	
						Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.)				10B. KIND OF BUSINESS OR INDUSTRY:			
Housewife				At Home			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Bloxom, Va				USA			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William James Somers				Margaret Anna Mears			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS:							
Mrs May R. Peterson, Salisbury, Md							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
174X IMMEDIATE CAUSE							
(A) <u>Adenocarcinoma Uterus</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-20-1953, to 6-23-1953, that I last saw the deceased alive on 6-23-1953, and that death occurred at 1:05 P M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED 6-23-1953	
John M. Bloxom III				M.D. 324 N. Division, Salisbury, Md			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		6-26-55		Parksley Cemetery		Parksley, Va	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
6-28-55		Mary W. Holloman		Henry M. Johnson, Parksley, Va.			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1955

BUREAU V. S.

6018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)12 TOWN SALISBURYLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS820 PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY WicomicoCITY (If outside corporate limits, write RURAL and give nearest town)
ORTOWN PittsvilleSTREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

EdwardBRITTINGHAM

4. DATE (Month)

(Day)

(Year)

OF

DEATH:

June 151955

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MalewhiteWIDOWED, DIVORCED,Jan 12, 187382 yrs.5 Months3 Days10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired)Retired Farmer10B. KIND OF BUSINESS
OR INDUSTRYOwn Farm

11. BIRTHPLACE (State or foreign country):

Pittsville, Md12. CITIZEN OF WHAT
COUNTRY?USA

13. FATHER'S NAME:

Robert Brittingham

14. MOTHER'S MAIDEN NAME:

Amelia White15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Mrs. Marie B. Wyden, Pittsville, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

BronchopneumoniaArteriosclerotic Cardiovascularrenal disease.INTERVAL BETWEEN
ONSET AND DEATH10 daysII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While ☐ Not while ☐
at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-9-55, 1955, to 6-15-55, 1955, that I last saw the deceasedalive on 6-15-55, 1955, and that death occurred at 1:55 P M, from the causes and on the date stated above.

SIGNATURE

William H. Lohr, Jr. M. D.

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

6-18-55Grace MethodistPittsville MdDATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-17-55Mary W. HollorayClay E. Dennis, Snow Hill, Md

MARGIN RESERVED FOR BINDING

RECEIVED

JUN 20 1955

BUREAU V. 1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06027

Item 14, wilmcl84 7-18-55 et

6019

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		2-1/2 mos.		TOWN <u>Chestertown</u>		14X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
91 <u>Deer's Head State Hospital</u>				Rt. 3			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Theophilus Karlton Bruce</u>				<u>June 22, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
<u>Male</u>	<u>Colored</u>	<u>Single</u>	<u>Nov. 10, 1877</u>	<u>77</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Houseman</u>		<u>--</u>		<u>Washington, D. C. USA</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Aaron Bruce</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease, decompensated</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						<u>6 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						<u>6 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Brain syndrome following cerebral thrombosis</u>						<u>4/16/55</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>--</u>		<u>--</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>--</u>		<u>--</u>					
22. I hereby certify that I attended the deceased from <u>Apr. 7, 1955</u> , to <u>June 22, 1955</u> , that I last saw the deceased alive on <u>June 22, 1955</u> , and that death occurred at <u>11:50A</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. V. Guerman (V. Guerman) M.D.</u>				ADDRESS (Street, city, town, state) <u>Deer's Head Hosp, Salisbury, Md.</u>		DATE SIGNED <u>6/22/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/25/55</u>		<u>Quaker Neck Cem.</u>		<u>Pomona, Md.</u>	
24. RECD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 28, 1955</u>		<u>Mary H. Holloway</u>		<u>James B. Bledwell</u>		<u>Easton, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

BUREAU V. S.

JUN 29 1955

RECEIVED

COUNTY OF MARYLAND DISTRICT OF BALTIMORE CITY OF BALTIMORE		DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS	
NAME OF DECEASED JOHN DOE		SEX MALE	
DATE OF BIRTH JAN 15 1910		PLACE OF BIRTH BALTIMORE, MARYLAND	
DATE OF DEATH JUN 25 1955		PLACE OF DEATH BALTIMORE, MARYLAND	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. SMITH		SIGNATURE OF REGISTRAR J. H. SMITH	
SIGNATURE OF WITNESS J. H. SMITH		SIGNATURE OF WITNESS J. H. SMITH	

INTENTIONAL

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06028

6020

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		TOWN <u>Salisbury</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>Since 8/20/51</u>		STREET ADDRESS <u>100 Lincoln Avenue</u>		(If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Herbert Lee Core</u>				<u>June 27 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 19, 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Ham</u>	11. BIRTHPLACE (State or foreign country) <u>Accomac, Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Washington Core</u>				14. MOTHER'S MAIDEN NAME <u>Mary Budd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk. 40</u>		16. SOCIAL SECURITY NO. <u>220-09-1993</u>		17. INFORMANT & ADDRESS <u>Mrs. Emma J. Logue 315 S. Haven, Salisbury, Md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>11 yrs.</u>			
IMMEDIATE CAUSE (A) <u>pulmonary tuberculosis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 20, 19 51</u> , to <u>June 27, 19 55</u> , that I last saw the deceased alive on <u>June 27, 19 55</u> , and that death occurred at <u>8 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. H. Shurden</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>6/28/55</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Funeral</u>		DATE THEREOF <u>June 29/55</u>		NAME OF CEMETERY OR CREMATORY <u>Whatevat Methodist</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR <u>June 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Eliza E. Hemmick</u>		ADDRESS <u>Snow Hill, Md</u>	

CERTIFICATE OF DEATH

0089

1. NAME OF DECEASED

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BUREAU V. S.

JUN 30 1955

RECEIVED

STATION 1241

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6021

CERTIFICATE OF DEATH

06029

332

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>1 day</u>		TOWN <u>White Haven</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Guy</u> (Middle) <u>WESLEY</u> (Last) <u>Covington</u>				(Month) <u>June</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>MARRIED</u>		<u>April 13, 1889</u>	
						9. AGE last birthday	
						<u>66</u> yrs. <u>2</u> Months <u>9</u> Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial Fishing</u>		11. BIRTHPLACE (State or foreign country) <u>Nantuxke, Md.</u>	
13. FATHER'S NAME <u>George W. Covington</u>				14. MOTHER'S MAIDEN NAME <u>Lucy E. Robertson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u>1220-26-8512</u>		17. INFORMANT & ADDRESS <u>Nida Covington, White Haven, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarct</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic coronary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/22</u>, 19<u>55</u>, to <u>6/22</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6/22</u>, 19<u>55</u>, and that death occurred at <u>9:30 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>W. R. Ellis Jr.</u>				DATE SIGNED <u>6-24-55</u>			
				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/25/55</u>		<u>Dobey Cemetery</u>		<u>White Haven, Md.</u>	
24. REGD BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 29, 1955</u>		<u>Mary T. Hollaway</u>		<u>C. J. Messitt</u>		<u>Bowie, Md.</u>	

CERTIFICATE OF DEATH

1. FULL NAME (PRINT OR TYPE)

2. PLACE OF DEATH

3. MARYLAND

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. AGE AT DEATH

8. SEX

9. RACE

10. OCCUPATION

11. CAUSE OF DEATH

12. MANNER OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF DEPARTMENT

21. SIGNATURE OF BUREAU

22. SIGNATURE OF OFFICE

23. SIGNATURE OF DIVISION

24. SIGNATURE OF SECTION

25. SIGNATURE OF UNIT

26. SIGNATURE OF BRANCH

27. SIGNATURE OF DISTRICT

28. SIGNATURE OF COUNTY

29. SIGNATURE OF CITY

30. SIGNATURE OF TOWN

31. SIGNATURE OF VILLAGE

32. SIGNATURE OF HAMLET

33. SIGNATURE OF COTTAGE

34. SIGNATURE OF HOUSE

35. SIGNATURE OF BUILDING

36. SIGNATURE OF STRUCTURE

37. SIGNATURE OF EDIFICE

38. SIGNATURE OF WORKS

39. SIGNATURE OF CONSTRUCTION

40. SIGNATURE OF BUILDING

41. SIGNATURE OF STRUCTURE

42. SIGNATURE OF EDIFICE

43. SIGNATURE OF WORKS

44. SIGNATURE OF CONSTRUCTION

45. SIGNATURE OF BUILDING

46. SIGNATURE OF STRUCTURE

47. SIGNATURE OF EDIFICE

48. SIGNATURE OF WORKS

49. SIGNATURE OF CONSTRUCTION

50. SIGNATURE OF BUILDING

51. SIGNATURE OF STRUCTURE

52. SIGNATURE OF EDIFICE

53. SIGNATURE OF WORKS

54. SIGNATURE OF CONSTRUCTION

55. SIGNATURE OF BUILDING

56. SIGNATURE OF STRUCTURE

57. SIGNATURE OF EDIFICE

58. SIGNATURE OF WORKS

59. SIGNATURE OF CONSTRUCTION

BUREAU V. S.

JUN 30 1955

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or coroner who has examined the body and determined the cause and manner of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6022

CERTIFICATE OF DEATH

06030

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>6 months</u>		TOWN <u>Federsburg</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Brooklyn Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Viola Emma Crumble</u>				<u>June 6 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Married</u>	<u>11/24/1911</u>	<u>43</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Housework</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Sam Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Stanley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>						<u>6 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of the cervix</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus - mild</u>						<u>?</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 30, 1954</u> , to <u>June 6, 1955</u> , that I last saw the deceased alive on <u>June 6, 1955</u> , and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u>		V. Juerman, M.D.		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>6/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federsburg, Md.</u>	
24. REC'D BY REGISTRAR <u>6-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son</u>		ADDRESS <u>Federsburg, Md.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6065

CERTIFICATE OF DEATH

06031

Reg. Dist. No.

Item 9, Film 182 6-15-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Wicomico Co</i>	STATE <i>MD</i> COUNTY <i>Wicomico</i>		
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <i>Delmar</i>		TOWN <i>Delmar MD</i> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<i>James O Cuff</i>		<i>June 4, 1955</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
<i>M.</i>	<i>White</i>	<i>Single</i>	<i>July 12, 1915</i>
9a. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>39 1/10</i> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	
<i>Labor</i>	<i>none</i>	<i>Wicomico Co</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>William Cuff</i>		<i>Daisy Price</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
	<i>770-01-8669</i>	<i>Daisy Cuff</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Coronary Thrombosis</i>			<i>Immediate</i>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
(C) <i>Ischemic aorta with valvular disease (or phlebotomy) (arterio-sclerotic and stenosis)</i>			<i>Unknown</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/1/1955</i> to <i>death</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>6/1</i> , 19 <i>55</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Ernest H. Larmore</i>		ADDRESS (Street, city, town, state) <i>100 Grove Delmar Del</i>	
DATE THEREOF <i>6-8-55</i>		DATE SIGNED <i>6/6/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)	
<i>Burial</i>	<i>Gloss Hill</i>	<i>Persimmonburg MD</i>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	
	<i>Mary H. Holloway</i>	<i>Decker H. Cuff</i>	
DATE <i>June 10, 1955</i>		ADDRESS	

BUREAU V. S.

JUN 10 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06032

6023

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>1 Wk</u>		CITY OR TOWN <u>Fruitland</u>		(If rural give location) <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>324 1/2 Camden Ave.</u>				STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>ANDREW JEFFERSON DASHIELL</u>				4. DATE OF DEATH (Month) <u>6</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 24, 1863</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Train Dashiell</u>				14. MOTHER'S MAIDEN NAME <u>Ellen M. Hurley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Ed. B. Dashiell, Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/19, 19 55</u> , to <u>4/6, 19 55</u> , that I last saw the deceased alive on <u>4/6, 19 55</u> , and that death occurred at <u>5:24</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Norman T. Baker</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		LOCATION (City, town, or county) <u>Wicomico Co.</u> (State)	
24. REC'D BY REGISTRAR <u>June 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

NAME: William T. Smith
 SEX: Male
 RACE: White
 BIRTH: Feb. 24, 1903
 PLACE OF BIRTH: Frederick, Md.
 OCCUPATION: Farmer
 MARITAL STATUS: Married
 DECEASED: June 4, 1955
 PLACE OF DEATH: Frederick, Md.
 CAUSE OF DEATH: Heart Disease
 MEDICAL ATTENDANCE: Dr. J. H. Smith
 CORONER: John D. Smith
 SIGNATURE: John D. Smith
 OFFICIAL: John D. Smith

BUREAU V. S.

JUN 6 1955

RECEIVED

The Hill & Johnson Co. Inc.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6024

CERTIFICATE OF DEATH

Reg. Dist. No. 332

06033

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>58 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Old River Road</u>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>James</u> <u>Geely</u>				DEATH: <u>June</u> <u>20</u> <u>1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>Apr. 11, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired): <u>Druck Hayer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Masonry</u>		11. BIRTHPLACE (State or foreign country): <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Geely</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Lynch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u> <u>072-09-9012</u>		17. INFORMANT & ADDRESS: <u>Sue M. Geely, Blades, Del</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Degenerative Heart Disease</u>						<u>unknown</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-23</u> , 19 <u>55</u> , to <u>6-20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-19</u> , 19 <u>55</u> , and that death occurred at <u>3:50</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>W. Ellis</u>		ADDRESS <u>Salisbury, Md</u>		DATE SIGNED <u>6-20-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>6-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		LOCATION (City, town, or county) (State) <u>Seaford, Del.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>W. B. Harrison</u>		ADDRESS <u>Seaford, Del.</u>	

RECEIVED

JUN 23 1955

BUREAU V. S.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6025

CERTIFICATE OF DEATH

06034

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
82 <u>Peninsula General Hospital</u>				620 Smith Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Dise</u>				<u>June 28, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>White</u>		<u>June 28, 1955</u>	Yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elwood Lewis Dise</u>				<u>Janet Virginia Brewington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A)				<u>Prematurity -</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/28/55</u> , to <u>6/28/55</u> , that I last saw the deceased alive on <u>6/28/55</u> , and that death occurred at <u>4:55</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury</u>		DATE SIGNED <u>Maryland</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>cremation</u>		<u>6/29/55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>6-29-55</u>		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>		<u>Salisbury</u>	
2065211200							

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. COLOR

9. RELIGION

10. EDUCATION

11. SERVICE

12. PLACE OF DEATH

13. CAUSE OF DEATH

14. MANNER OF DEATH

15. TIME OF DEATH

16. PLACE OF BURIAL

17. NAME OF FUNERAL HOME

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF CLERK

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF CONSTABLE

27. SIGNATURE OF TOWNSHIP CLERK

28. SIGNATURE OF COUNTY CLERK

29. SIGNATURE OF STATE CLERK

30. SIGNATURE OF U.S. MARSHAL

31. SIGNATURE OF U.S. DEPUTY MARSHAL

32. SIGNATURE OF U.S. SHERIFF

33. SIGNATURE OF U.S. CONSTABLE

34. SIGNATURE OF U.S. TOWNSHIP CLERK

35. SIGNATURE OF U.S. COUNTY CLERK

36. SIGNATURE OF U.S. STATE CLERK

37. SIGNATURE OF U.S. U.S. MARSHAL

38. SIGNATURE OF U.S. U.S. DEPUTY MARSHAL

39. SIGNATURE OF U.S. U.S. SHERIFF

40. SIGNATURE OF U.S. U.S. CONSTABLE

41. SIGNATURE OF U.S. U.S. TOWNSHIP CLERK

42. SIGNATURE OF U.S. U.S. COUNTY CLERK

43. SIGNATURE OF U.S. U.S. STATE CLERK

44. SIGNATURE OF U.S. U.S. U.S. MARSHAL

45. SIGNATURE OF U.S. U.S. U.S. DEPUTY MARSHAL

46. SIGNATURE OF U.S. U.S. U.S. SHERIFF

47. SIGNATURE OF U.S. U.S. U.S. CONSTABLE

48. SIGNATURE OF U.S. U.S. U.S. TOWNSHIP CLERK

49. SIGNATURE OF U.S. U.S. U.S. COUNTY CLERK

50. SIGNATURE OF U.S. U.S. U.S. STATE CLERK

51. SIGNATURE OF U.S. U.S. U.S. U.S. MARSHAL

52. SIGNATURE OF U.S. U.S. U.S. U.S. DEPUTY MARSHAL

53. SIGNATURE OF U.S. U.S. U.S. U.S. SHERIFF

54. SIGNATURE OF U.S. U.S. U.S. U.S. CONSTABLE

55. SIGNATURE OF U.S. U.S. U.S. U.S. TOWNSHIP CLERK

56. SIGNATURE OF U.S. U.S. U.S. U.S. COUNTY CLERK

57. SIGNATURE OF U.S. U.S. U.S. U.S. STATE CLERK

BUREAU V. 2

JUL 1 1955

RECEIVED

10-22-55 filed in Maryland

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6026

CERTIFICATE OF DEATH

06035

Reg. Dist. No. 332

Dr. Gramse, Fred

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>SALISBURY</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>423 ELIZABETH STREET</u>			
3. NAME OF DECEASED (Type or Print) <u>Lillie MAY DRISCOLL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 6 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 17, 1980</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
					2	19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Round</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Richardson, Emily</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Arthur Betts, Salisbury, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-31, 1955</u> , to <u>6-6, 1955</u> , that I last saw the deceased alive on <u>6-6, 1955</u> , and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Fred R. Gramse</u>		M.D. <u>Salisbury, Md</u>		ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 8, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DATE OF DEATH

PLACE OF DEATH

USUAL RESIDENCE (HOMER OF DECEASED)

MARYLAND

COUNTY

DATE OF DEATH

PLACE OF DEATH

MARYLAND

DATE OF DEATH

USUAL RESIDENCE (HOMER OF DECEASED)

PLACE OF DEATH

MARYLAND

USUAL RESIDENCE (HOMER OF DECEASED)

DATE OF DEATH

PLACE OF DEATH

USUAL RESIDENCE (HOMER OF DECEASED)

BUREAU V. S.

JUN 8 1955

RECEIVED

DATE OF DEATH

USUAL RESIDENCE (HOMER OF DECEASED)

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06036

6027

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Salisbury, Md.</u>		<u>Since 2/8/51</u>		TOWN <u>Princess Anne</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route #1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Earl William Ennis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 17 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 9, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Gilford, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Annis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Thorns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-07-7921</u>		17. INFORMANT & ADDRESS <u>Patient when admitted</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>002X</u> (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pulmonary Tuberculosis</u>						<u>4 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 8</u> , 19 <u>51</u> , to <u>June 17</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>51</u> , and that death occurred at <u>11:55pM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>6/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>6/20/55</u>	NAME OF CEMETERY OR CREMATORY <u>Liberty</u>		LOCATION (City, town, or county) <u>Parkersley</u>		(State) <u>Va.</u>	
24. REC'D BY REGISTRAR <u>6-23-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson</u>		ADDRESS <u>Va.</u>		

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06037

6028

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		Most of life		TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - 606 A Westover Circle				STREET ADDRESS (If rural give location) 606 A Westover Circle			
3. NAME OF DECEASED (First) (Middle) (Last) George Washington Games				4. DATE OF DEATH (Month) (Day) (Year) 6 - 24 - 19 55			
5. SEX Male	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 7-9-1886	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months 11 Days 16	IF UNDER 24 HRS. Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lawns & Gardens		11. BIRTHPLACE (State or foreign country) Polks Road, Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry Games				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 217-10-3832		17. INFORMANT & ADDRESS Salisbury, Md. Mrs. Odessa Ames, 610 Westover Circle			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) Carcinoma Prostate				INTERVAL BETWEEN ONSET AND DEATH Unk.			
ANTECEDENT CAUSE(S) DUE TO (B) Unknown							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Congestive Heart Disease				3 weeks			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 25, 1955, to June 24, 1955, that I last saw the deceased alive on June 23, 1955, and that death occurred at 1:20 P.M. from the causes and on the date stated above.							
SIGNATURE <i>L. Herbert Sembley</i>				DATE SIGNED 6/27/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-27-55		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Md.	
24. REC'D BY REGISTRAR DATE June 29, 1955		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Mary A. Stewart</i>			
				ADDRESS 324 E Church St. Salisbury, Maryland			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME: **Male**
 SEX: **A.M.**
 DATE OF BIRTH: **March 23 1885**
 PLACE OF BIRTH: **Germany**
 OCCUPATION: **Laborer**
 US CITIZENSHIP: **None**
 MARITAL STATUS: **Married**
 DECEASED AT: **Home - 608 A. Webster Circle**
 CITY: **Baltimore**
 COUNTY: **Harford**
 STATE: **Md.**
 DECEASED ON: **June 28 1955**
 TIME OF DEATH: **11:15 A.M.**
 CAUSE OF DEATH: **Heart Disease**
 MEDICAL HISTORY: **None**
 SIGNATURE OF DECEASED: **None**
 SIGNATURE OF WITNESSES: **None**
 SIGNATURE OF PHYSICIAN: **None**
 SIGNATURE OF CORONER: **None**
 SIGNATURE OF JURY: **None**
 SIGNATURE OF DEATH REGISTRAR: **None**

BUREAU V. S.

JUN 28 1955

RECEIVED

6-28-55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06038

6929

CERTIFICATE OF DEATH

Reg. Dist. No. 46

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		CITY (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
CITY (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		LENGTH OF STAY (in this place) <u>2 mo. 20 days</u>		TOWN <u>Salisbury, Maryland</u>		TOWN <u>Baltimore City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (if rural give location) <u>605 St. Dunstons Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Eva</u> (Middle) <u>Mae</u> (Last) <u>Holland</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>20</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 6, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Spear</u>				14. MOTHER'S MAIDEN NAME <u>Mary Goslin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Aspiration Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Hemorrhage</u>				2 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertensive cardiovascular disease</u>				?			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 28, 19 55</u> , to <u>June 20, 19 55</u> , that I last saw the deceased alive on <u>June 20, 19 55</u> , and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>A. McElhin</u> M.D. <u>Salisbury, Maryland</u> DATE SIGNED <u>6/20/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-23-1955</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		LOCATION (City, town, or county) (State) <u>East New Market Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rexaeth B. Thomas</u> ADDRESS <u>Cambury Md.</u>			
DATE <u>June 21, 1955</u>							

CERTIFICATE OF DEATH

10329

1. DECEASED'S NAME (Last, first, middle initial) OR NUMBER

DECEASED'S NAME

DATE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Burial Society

Signature of Burial Association

Signature of Burial Club

Signature of Burial League

Signature of Burial Order

Signature of Burial Society

Signature of Burial Association

Signature of Burial Club

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Signature of Burial Association

Signature of Burial Club

Signature of Burial League

Signature of Burial Order

Signature of Burial Society

Signature of Burial Association

Signature of Burial Club

Signature of Burial League

BUREAU V. S.

JUN 22 1955

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the physician or coroner who has examined the body and determined the cause of death.

2. The cause of death should be stated in full, including the immediate, underlying, and contributing causes.

3. The mode of death should be stated, such as natural, accidental, suicidal, homicidal, or undetermined.

4. The place of death should be stated, such as home, hospital, nursing home, or elsewhere.

5. The signature of the physician or coroner should be written in the space provided.

6. The signature of the registrar should be written in the space provided.

7. The signature of the burial officer should be written in the space provided.

8. The signature of the undertaker should be written in the space provided.

9. The signature of the funeral home should be written in the space provided.

10. The signature of the cemetery should be written in the space provided.

11. The signature of the burial society should be written in the space provided.

12. The signature of the burial association should be written in the space provided.

13. The signature of the burial club should be written in the space provided.

14. The signature of the burial league should be written in the space provided.

15. The signature of the burial order should be written in the space provided.

16. The signature of the burial society should be written in the space provided.

17. The signature of the burial association should be written in the space provided.

18. The signature of the burial club should be written in the space provided.

19. The signature of the burial league should be written in the space provided.

20. The signature of the burial order should be written in the space provided.

21. The signature of the burial society should be written in the space provided.

22. The signature of the burial association should be written in the space provided.

23. The signature of the burial club should be written in the space provided.

24. The signature of the burial league should be written in the space provided.

25. The signature of the burial order should be written in the space provided.

26. The signature of the burial society should be written in the space provided.

27. The signature of the burial association should be written in the space provided.

28. The signature of the burial club should be written in the space provided.

29. The signature of the burial league should be written in the space provided.

30. The signature of the burial order should be written in the space provided.

31. The signature of the burial society should be written in the space provided.

32. The signature of the burial association should be written in the space provided.

33. The signature of the burial club should be written in the space provided.

34. The signature of the burial league should be written in the space provided.

35. The signature of the burial order should be written in the space provided.

36. The signature of the burial society should be written in the space provided.

37. The signature of the burial association should be written in the space provided.

38. The signature of the burial club should be written in the space provided.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06039

6030

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) 2 months		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS (If rural give location) 1901 Edmondson Avenue			
3. NAME OF DECEASED (Type or Print) Lillian (First) Holloman (Middle) (Last)				4. DATE OF DEATH (Month) June (Day) 21 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12/26/1901	9. AGE last birthday 53 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Carr				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 193X IMMEDIATE CAUSE (A) Glioblastoma multiforme						3 years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerotic cardiovascular disease						?	
19a. DATE OF OPERATION --		19b. MAJOR FINDINGS OF OPERATION --				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) --		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) --			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) --		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? --			
22. I hereby certify that I attended the deceased from April 20, 19 55, to June 21, 19 55, that I last saw the deceased alive on June 21, 19 55, and that death occurred at 9 A. M. from the causes and on the date stated above.							
SIGNATURE M. V. Juerman		V. Juerman, M.D.		ADDRESS (Street, city, town, state) Deer's Head State Hospital, M.D. Salisbury, Maryland		DATE SIGNED 6/21/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-26-55		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR June 24, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 324 E. Church St. Salisbury, Maryland	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6031

06040

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural, give location) 1226 North Division St.			
3. NAME OF DECEASED: (First) ANNA (Middle) SIPLE (Last) JACKSON		4. DATE OF DEATH JUNE 10 th 19 55		5. AGE last birthday: 93 yrs.		6. MONTHS 6 DAYS 11 HOURS MIN. 	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Nov. 29th 1861	9. AGE last birthday: 93 yrs.		10. IF UNDER 1 YEAR: 6 Months 11 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY: At own home		11. BIRTHPLACE (State or foreign country): Greenback West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George W. Siple				14. MOTHER'S MAIDEN NAME: Hannah Warrick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Maude Arbogust (Daughter) 1226 St. Salisbury, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
420.0 Immediate cause (a) Coronary occlusion - Antecedent cause(s) (b) Arterio-sclerotic heart disease Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						hours	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE E. H. Boyer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED June 10 1955 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: Jun. 12, 1955		NAME OF CEMETERY OR CREMATORY: Parsons Cemetery		LOCATION (City, town, or county) (State): Salisbury, Maryland	
DATE REC'D BY LOCAL REG. 6-10-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY		ADDRESS: SALISBURY MARYLAND	

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BUREAU V. S.

JUN 13 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. **332**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Wicomico	CITY (If outside corporate limits write RURAL OR and give nearest town) Salisbury	STATE MD	COUNTY Wicomico
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) Salisbury Md	STREET ADDRESS (If rural, give location) Lake St
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Jessie	(Middle)	(Last) Jackson	(Month) 6 (Day) 27 (Year) 1955
5. SEX: M	6. COLOR OR RACE: col	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: 15 July 1907
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: none	9. AGE last birthday: 48 yrs.
11. BIRTHPLACE (State or foreign country): Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Lawrence Jackson		14. MOTHER'S MAIDEN NAME: Emma Adams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: 264-01-6011	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: City Police Dept	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET OF DEATH
Immediate cause (a) Coronary occlusion			sudden
Antecedent cause(s) (b) Arterio-sclerosis			yes
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE Emil C. Royer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-28-55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): burial	DATE THEREOF 7-5-55	NAME OF CEMETERY OR CREMATORY East Valley Cem	LOCATION (City, town, or county) (State) St Valley Ga.
DATE REC'D BY LOCAL REG. 6-30-55	REGISTRAR'S SIGNATURE Mary W. Holloway	24. FUNERAL DIRECTOR Booker M. West ADDRESS Salisbury Md.	

6032

06041

RECEIVED

JUL 5 1955

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12-15-45
11-15-45

6066

06042

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

I. PLACE OF DEATH:

COUNTY Wicomico

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Nanticoke

LENGTH OF STAY (If in this place)

Lifetime

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Nanticoke River

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits write RURAL and give nearest town)

OR TOWN Jesterville, Md.

STREET ADDRESS (If rural, give location)

1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JohnFerdinandJester

4. DATE OF DEATH

(Month)

(Day)

(Year)

6251955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

MWSingle5/25/1895607171111

10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

FarmerTen. StoreJesterville, Md.U.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Wilfred JesterLola Sommers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give year or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

yesWorld War IJohn Jester, Jesterville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

929.8

Immediate cause

(a)

Drowning

DUE TO

Sudden

Antecedent cause(s)

(b)

Diseases or conditions, if any,

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, etc.) OF INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐ , Inspection ☒ , Inquiry ☒ , and find that death resulted from: Natural causes ☐ , Accident ☐ , Suicide ☐ , Homicide ☐ , Undetermined cause ☐ .

SIGNATURE

CHIEF MEDICAL EXAMINER

DATE SIGNED

Earl E. Royce6-25-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE DEC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-28-55Mary W. HollowayCornelius J. Messick, Picoche, Maryland

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 30 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06043

6033

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>10 WKS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>702 Camden Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Tennie Connelly Johnson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 3 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 10, 1866</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Connelly</u>				14. MOTHER'S MAIDEN NAME <u>Emily Humpherys</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Rollie Gillis, Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-1</u> , 19 <u>55</u> , to <u>6-3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-3</u> , 19 <u>55</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>John M. Bloforn III</u>		DATE THEREOF <u>6/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>June 6, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>			
				ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. PLACE OF DEATH

2. SEX

3. AGE

4. OCCUPATION

5. DATE OF DEATH

6. PLACE OF BIRTH

7. MANNER OF DEATH

8. CAUSE OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DEATH REGISTRAR

BUREAU V. S.

JUN 6 1955

RECEIVED

12. SIGNATURE OF DEATH REGISTRAR

13. SIGNATURE OF DEATH REGISTRAR

The WILL & JOHNSON CO., BALTIMORE, MD.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06044

6034

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>11 days</u>		TOWN <u>Cambridge</u>		<u>09-13-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>415 High Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Sarah Lizzie Johnson</u>				<u>June 25 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>Aug. 3, 1900</u>	<u>54</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>Unknown</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Josiah Johnson</u>				<u>Willie Stiles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>332x</u> IMMEDIATE CAUSE (A) <u>Progressive cerebral thrombosis with paraplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo. ?</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerosis, general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>- -</u>		<u>- -</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<u>- -</u>		<u>- -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>- -</u>		<u>M.</u>		<u>- -</u>			
22. I hereby certify that I attended the deceased from June 14, 1955, to June 25, 1955, that I last saw the deceased alive on June 25, 1955, and that death occurred at 12:15 PM, from the causes and on the date stated above.							
SIGNATURE		V. Juerman, M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>V. Juerman</u>		<u>Deer's Head State Hospital</u>		<u>M.D. Salisbury, Maryland</u>		<u>6/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/29/1955</u>		<u>Bethel Cemetery</u>		<u>Cambridge, Maryland</u>	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 29, 1955</u>		<u>Mary H. Holloway</u>		<u>Herbert M. St. Clair, Jr.</u>		<u>Cambridge, Md</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6035

CERTIFICATE OF DEATH

Reg. Dist. No. 332

06045

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)	
<u>12</u> <u>Salisbury</u>				<u>Princess Ann</u> <u>18X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82</u> <u>Lincoln General Hospital</u>				STREET ADDRESS <u>V</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Katie</u> <u>Jones</u>				OF DEATH: <u>June</u> <u>13</u> - 19 <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>E</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>None</u>		8. DATE OF BIRTH: <u>Oct 5 - 1890</u>	
9. AGE last birthday <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Stanford Va</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>on known</u>			
14. MOTHER'S MAIDEN NAME: <u>on known</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS: <u>John Jones Princess Somerset Co Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>6 wks</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertension</u>						<u>Unk.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Obesity</u>						<u>Unk.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21c. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-2-55</u> , to <u>June 10, 1955</u> , that I last saw the deceased alive on <u>June 7, 1955</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>G. Herbert Samboley</u> M.D.				ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>June 13, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 14, 55</u>		<u>John Wesley</u>		<u>Princess Anne Somerset Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-13-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Charles H. Ward</u>		ADDRESS <u>Marion St Md</u>	

BUREAU V. 3

JUN 15 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06046

6067

CERTIFICATE OF DEATH

Dr. Lee Lawry

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Fruitland				OR TOWN Fruitland		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (First) (Middle) (Last) MARY ANNA JONES				4. DATE OF DEATH (Month) (Day) (Year) June 24 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 9, 1871		9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months 4 Days 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At own home		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Trehearn				14. MOTHER'S MAIDEN NAME Caroline Long			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Marion Stevenson (Son) R.D. Eden, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
434.1 IMMEDIATE CAUSE (A) CONGESTIVE HEART FAILURE						1 yr.	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JUN 24 55 to JUN 24 55 that I last saw the deceased alive on JUN 24 55 and that death occurred at 9:30 P.M. from the causes and on the date stated above.							
SIGNATURE Lee Lawry		M.D. Fruitland, Maryland		ADDRESS (Street, city, town, state) June 25 1955		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jun. 26, 1955		NAME OF CEMETERY OR CREMATORY Salom Meth. Church Cem.		LOCATION (City, town, or county) (State) Pocomoke, Maryland	
24. REG'D BY REGISTRAR June 27, 1955		REGISTRAR'S SIGNATURE Mary H. Hallaway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
				ADDRESS SALISBURY MARYLAND			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Dr. J. Lee Smith

NAME OF DEATH

Widow's

Maryland

Maryland

Widow's

Widow's

Widow's

MALE

MALE

MALE

MALE

MALE

Female

White

White

White

White

White

House Work

At own home

Worcester Co. Maryland

USA

Thomas Freeman

Caroline Long

Mr. Arthur Stevenson (Son) R.M. Eden, Md.

IN MEDICAL CERTIFICATION

BUREAU V. 3

JUN 27 1955

2:10 PM

RECEIVED

HOLLAND & COMPANY BALTIMORE MARYLAND

June 22, 1955

John M. Smith, M.D.

Frederick, Maryland

June

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06047

6036 CERTIFICATE OF DEATH

Dr. Beardsley

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN Salisbury		LENGTH OF STAY (in this place)		CITY OR TOWN Parsonsborg		Rural Rural X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS R.D.		(if rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CORA		(Middle) ELLEN		(Last) KELLEY		(Month) (Day) (Year) June 14 th 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 1, 1890	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				Months 11 Days 13		Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at own home		11. BIRTHPLACE (State or foreign country) R.D. Salisbury Md Wico. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asbury Hammond				14. MOTHER'S MAIDEN NAME Olevia Ennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Carlos G. Kelley (husband) R.D.# Parsonsburg, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				1 day			
331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				1 yr. +			
ANTECEDENT CAUSE(S) DUE TO essential hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) degenerative heart disease				1 yr. +			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 25, 1955, to June 14, 1955, that I last saw the deceased alive on June 14, 1955, and that death occurred at 3:50P.M. from the causes and on the date stated above.							
SIGNATURE Carl W. Beardsley				DATE SIGNED June 14 1955			
ADDRESS (Street, city, town, state) East Church St Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 17, 1955		NAME OF CEMETERY OR CREMATORY Hammond Cemetery		LOCATION (City, town, or county) (State) R.D.# Salisbury, Maryland	
24. REG'D BY REGISTRAR June 16, 1955		REGISTRAR'S SIGNATURE Mary W. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

DEPARTMENT OF HEALTH - BALTIMORE, MD CERTIFICATE OF DEATH

Dr. [Name]

[Name]

[Name]

[Name]

[Name]

[Name]

[Name]

[Name]

[Name]

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[Name]

[Name]

[Name]

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[Name]

[Name]

[Name]

[Name]

[Name]

[Name]

[Name]

BUREAU V. 2

JUN 16 1955

RECEIVED

[Name]

[Name]

[Name]

[Name]

[Name]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06048

6037

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>21 days</u>		TOWN <u>SALISBURY</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>82 PENINSULA GENERAL HOSPITAL</u>				<u>519 Willow STREET</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>SAMUEL</u> (First) <u>KERNEY</u> (Last)				<u>JUNE</u> (Month) <u>11</u> (Day) <u>1955</u> (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>A.A.</u>	<u>MARRIED</u>	<u>8-18-1884</u>	<u>70</u> yrs.	<u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	<u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>LABORER</u>		<u>FARMING</u>		<u>Weldon, N.C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>UNKNOWN</u>				<u>HANNAH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>yes</u>		<u>11-1-17-7-19-19</u>		<u>519 Willow St.</u> <u>Mrs. Clara Kerney Salisbury, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Convulsive Seizures death 7.7 days</u>				<u>17 days</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Mild Cerebral Accident</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Carcinoma of lung</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Arteriosclerosis & Hypertension</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 22, 1955</u>, to <u>June 10, 1955</u>, that I last saw the deceased alive on <u>June 7, 1955</u>, and that death occurred at <u>2:05</u> P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>D. Herbert Lemble</u>				<u>6/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6-14-55</u>		<u>GREEN ACRES Memorial Park</u>		<u>SALISBURY Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 15, 1955</u>		<u>Mary H. Holloway</u>		<u>J.F. STEWART FUNERAL HOME</u>		<u>Salisbury, Md.</u>	

1915

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

DEATH CERTIFICATE

Form No. 1

REGISTRATION DISTRICT OF BALTIMORE

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF BURIAL

NAME OF MINISTER OF THE GOSPEL

BUREAU V. S.

JUN 15 1915

RECEIVED

STEWART BUREAU

REGISTRATION DISTRICT OF BALTIMORE

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 15th day of June, 1915.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06049

6038

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury, Maryland</u>		1 mo.		TOWN <u>Easton, Maryland</u>		20402	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
9/ Deer's Head State Hospital				Plum Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Nellie B. Lambert				June 12 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Feb. 17, 1869	86 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				Milton, Del.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
G.W. Burke				Ellen See			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
unk		unk		Hospital Records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A)						Cerebral Hemorrhage	
ANTECEDENT CAUSE(S) DUE TO						Hypertensive Cardiovascular Disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						unk	
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 12, 1955, to June 12, 1955, that I last saw the deceased alive on June 12, 1955, and that death occurred at 1:55 P.M. from the causes and on the date stated above.							
SIGNATURE <u>W. Malhe</u>				DATE SIGNED <u>June 12, 1955</u>			
				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 15, 55</u>		<u>Spring Hill</u>		<u>Easton</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>6/15/55</u>		<u>N.H. Neerius</u>		<u>W. Malhe</u>		<u>Easton Md</u>	
<u>6-19-55</u>		<u>Mary W. Holloway</u>					

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

PLACE OF DEATH _____		COUNTY _____	
NAME OF DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
NAME OF PHYSICIAN _____		SIGNATURE OF PHYSICIAN _____	
NAME OF CORONER _____		SIGNATURE OF CORONER _____	
NAME OF REGISTRAR _____		SIGNATURE OF REGISTRAR _____	

RECEIVED

RECEIVED
 JUN 22 1955
 BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06050

6939

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>4 years</u>		TOWN <u>Federalsburg - River Road</u>		<u>09x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MINNIE MAE LARKIN</u>				<u>6 11 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>1/20/1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Housework</u>		<u>Butler, Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John W. Bortmas</u>				<u>Priscilla C. Fry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>- -</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>4 yrs</u>	
<u>Senile osteoporosis with compression fracture of midthoracic vertebrae</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 25, 1951</u>, to <u>June 11, 1955</u>, that I last saw the deceased alive on <u>June 11, 1955</u>, and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<u>L.V. Maldve</u>		<u>L.V. Maldve, M.D.; Deer's Head State Hospital</u>				<u>6/11/55</u>	
		<u>Salisbury, Maryland</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 13, 1955</u>		<u>Hill Crest Cemetery</u>		<u>Federalsburg, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6-15-55</u>		<u>Mary W. McElroy</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			

CERTIFICATE OF DEATH

1955

1. PLACE OF DEATH

2. SEX

3. RACE

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. PLACE OF DEATH

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55. PLACE OF DEATH

BUREAU V. S.

JUN 17 1955

RECEIVED

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06051

6040

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>6 days</u>		TOWN <u>GIRDLTREE</u>		<u>23X-2U</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 PENINSULA GENERAL HOSPITAL</u>				<u>1401 Umuh, ave Phila, Pa.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>MILDRED</u>		<u>L.</u>		<u>LEONARD</u>		<u>JUNE 9 1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>7</u>	<u>White</u>	<u>MARRIED</u>	<u>Jan-11-1912</u>	<u>43/4/25</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>own home</u>		<u>Stockton, Md</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>G. Walter Taylor</u>				<u>Eve Ward</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Michelle Leonard, Phila Pa 3rd 11</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>591X IMMEDIATE CAUSE (A) <u>Uremia</u></u>				<u>1401 Umuh ave.</u>		<u>10 days</u>	
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Toxic Nephrosis</u></u>						<u>14</u>	
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Carcinoma of Uterus</u>		<u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-3</u>, 19<u>55</u>, to <u>6-9</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6-9</u>, 19<u>55</u>, and that death occurred at <u>2:15 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>William R. Ellis Jr. M.D.</u>				<u>Salisbury, Md.</u>		<u>6-9-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 11/55</u>		<u>Bates Memorial</u>		<u>Snow Hill, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 6-10-55</u>		<u>Mary W. Holloway</u>		<u>Clay E. Harris</u>		<u>Snow Hill, Md</u>	

CERTIFICATE OF DEATH

Form 100-10-10

1. DECEASED'S NAME (Last, first, middle initial)

2. PLACE OF DEATH

3. SEX () Male () Female

4. DATE OF BIRTH (Month, day, year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (If deceased was engaged in any occupation)

7. CAUSE OF DEATH (Immediate cause)

8. MANNER OF DEATH () Natural () Accidental () Suicide () Homicide () Undetermined

9. DATE OF DEATH (Month, day, year)

10. SIGNATURE OF PHYSICIAN (If death was certified by a physician)

11. SIGNATURE OF CORONER (If death was certified by a coroner)

12. SIGNATURE OF DEATH REGISTRAR (If death was certified by a death registrar)

13. SIGNATURE OF VITALS SECTION (If death was certified by the vital statistics section)

14. SIGNATURE OF COUNTY CLERK (If death was certified by the county clerk)

15. SIGNATURE OF CITY CLERK (If death was certified by the city clerk)

16. SIGNATURE OF TOWN CLERK (If death was certified by the town clerk)

17. SIGNATURE OF VILLAGE CLERK (If death was certified by the village clerk)

18. SIGNATURE OF POST OFFICE CLERK (If death was certified by the post office clerk)

19. SIGNATURE OF SCHOOL CLERK (If death was certified by the school clerk)

20. SIGNATURE OF CHURCH CLERK (If death was certified by the church clerk)

BUREAU V. S.

JUN 13 1955

RECEIVED

UNOFFICIAL

THIS IS NOT A VALID CERTIFICATE OF DEATH

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 2 & 4, Film G 183, 6-24-55 h

06052

5041

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i> MD. <i>md.</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> TOWN <i>Salisbury</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1 Lane Ave</i>				STATE <i>md.</i> COUNTY <i>Wicomico</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> TOWN <i>Salisbury</i> STREET ADDRESS (If rural give location) <i>1 Lane Ave</i>			
3. NAME OF DECEASED (Type or Print) <i>Charles (First) (Middle) (Last) Peter</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>6 15 19 55</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Cel</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>18 78</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Barber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Barber</i>		11. BIRTHPLACE (State or foreign country) <i>White Haven md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>William Peter</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>				<i>undetermined</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>14 May 19 55</i> , to <i>15 June 19 55</i> , that I last saw the deceased alive on <i>15 June 19 55</i> , and that death occurred at <i>138 M.</i> from the causes and on the date stated above.							
SIGNATURE <i>H. F. Funnell</i>				ADDRESS (Street, city, town, state) <i>602 N. Main St. Salisbury, Md.</i> DATE SIGNED <i>17 June 55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>June 18</i>	NAME OF CEMETERY OR CREMATORY <i>White Haven</i>		LOCATION (City, town, or county) (State) <i>White Haven md</i>		
24. REC'D BY REGISTRAR <i>June 21, 1955</i>		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Booker Mack</i> ADDRESS			

CERTIFICATE OF DEATH

Reg. No. 10

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Signature of registrar

10. Signature of coroner

11. Signature of jury

12. Signature of witnesses

13. Signature of funeral director

14. Signature of undertaker

15. Signature of cemetery

16. Signature of burial society

17. Signature of church

18. Signature of school

19. Signature of hospital

20. Signature of other

21. Signature of family

22. Signature of friends

23. Signature of neighbors

24. Signature of others

25. Signature of witnesses

26. Signature of jury

27. Signature of coroner

28. Signature of witnesses

29. Signature of family

30. Signature of friends

31. Signature of neighbors

32. Signature of others

33. Signature of witnesses

34. Signature of jury

35. Signature of coroner

36. Signature of witnesses

37. Signature of family

38. Signature of friends

39. Signature of neighbors

40. Signature of others

41. Signature of witnesses

42. Signature of jury

43. Signature of coroner

44. Signature of witnesses

45. Signature of family

46. Signature of friends

47. Signature of neighbors

48. Signature of others

49. Signature of witnesses

50. Signature of jury

51. Signature of coroner

52. Signature of witnesses

53. Signature of family

54. Signature of friends

55. Signature of neighbors

56. Signature of others

57. Signature of witnesses

58. Signature of jury

59. Signature of coroner

60. Signature of witnesses

61. Signature of family

62. Signature of friends

63. Signature of neighbors

64. Signature of others

65. Signature of witnesses

66. Signature of jury

67. Signature of coroner

68. Signature of witnesses

69. Signature of family

70. Signature of friends

71. Signature of neighbors

72. Signature of others

73. Signature of witnesses

74. Signature of jury

75. Signature of coroner

76. Signature of witnesses

77. Signature of family

78. Signature of friends

79. Signature of neighbors

80. Signature of others

81. Signature of witnesses

82. Signature of jury

83. Signature of coroner

84. Signature of witnesses

85. Signature of family

86. Signature of friends

87. Signature of neighbors

88. Signature of others

89. Signature of witnesses

90. Signature of jury

91. Signature of coroner

92. Signature of witnesses

93. Signature of family

94. Signature of friends

95. Signature of neighbors

96. Signature of others

97. Signature of witnesses

98. Signature of jury

99. Signature of coroner

100. Signature of witnesses

101. Signature of family

102. Signature of friends

103. Signature of neighbors

104. Signature of others

105. Signature of witnesses

106. Signature of jury

107. Signature of coroner

108. Signature of witnesses

109. Signature of family

110. Signature of friends

111. Signature of neighbors

112. Signature of others

113. Signature of witnesses

114. Signature of jury

115. Signature of coroner

116. Signature of witnesses

117. Signature of family

118. Signature of friends

119. Signature of neighbors

120. Signature of others

121. Signature of witnesses

122. Signature of jury

123. Signature of coroner

124. Signature of witnesses

125. Signature of family

126. Signature of friends

127. Signature of neighbors

128. Signature of others

129. Signature of witnesses

130. Signature of jury

131. Signature of coroner

132. Signature of witnesses

133. Signature of family

134. Signature of friends

135. Signature of neighbors

136. Signature of others

137. Signature of witnesses

138. Signature of jury

139. Signature of coroner

140. Signature of witnesses

BUREAU V. 1

JUN 21 1955

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06053

6042

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>7 months</u>		TOWN <u>Queenstown</u>		<u>17X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Francis</u> <u>Nathan</u> <u>Pinder</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>6</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>12/14/1921</u>		9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Queenstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Pinder</u>				14. MOTHER'S MAIDEN NAME <u>Emma Anthony</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-6253</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis - Post operative</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinson's disease</u>						<u>21 years</u>	
19a. DATE OF OPERATION <u>12/8/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>See University of Md. report</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>--</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>--</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 3, 1954</u> , to <u>June 6, 1955</u> , that I last saw the deceased alive on <u>June 6, 1955</u> , and that death occurred at <u>4:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u>				ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital, Salisbury, Maryland</u>		DATE SIGNED <u>6/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>June 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Centerville Cemetery</u>		LOCATION (City, town, or county) <u>Centerville, Maryland</u>	
24. REC'D BY REGISTRAR <u>June 7-55</u>		REGISTRAR'S SIGNATURE <u>Philip A. Matthews</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary G. Holloway</u>		ADDRESS <u>Centerville, Maryland</u>	

CERTIFICATE OF DEATH

File No. 100

1. USUAL RESIDENCE (House or Room)

MARYLAND

JOHN D. SMITH

2. DATE OF DEATH
JUN 10 1955

3. PLACE OF DEATH
HOME

4. CAUSE OF DEATH
HEART DISEASE

5. MANNER OF DEATH
NATURAL

6. SEX
MALE

7. AGE
65

8. OCCUPATION
FARMER

9. MARITAL STATUS
MARRIED

10. BIRTH DATE
JUN 10 1890

11. BIRTH PLACE
BALTIMORE, MD

12. RACE
WHITE

13. EDUCATION
HIGH SCHOOL

14. PREVIOUS ILLNESS
NONE

15. TIME OF DEATH
10:00 AM

16. SIGNATURE OF DECEASED
JOHN D. SMITH

17. SIGNATURE OF WITNESSES
J. D. SMITH

18. SIGNATURE OF PHYSICIAN
J. D. SMITH

19. SIGNATURE OF REGISTRAR
J. D. SMITH

20. SIGNATURE OF CLERK
J. D. SMITH

21. SIGNATURE OF JURY
J. D. SMITH

22. SIGNATURE OF JUDGE
J. D. SMITH

23. SIGNATURE OF SHERIFF
J. D. SMITH

24. SIGNATURE OF CONSTABLE
J. D. SMITH

25. SIGNATURE OF JAILER
J. D. SMITH

26. SIGNATURE OF PRISONER
J. D. SMITH

27. SIGNATURE OF WARDEN
J. D. SMITH

28. SIGNATURE OF CHIEF OF POLICE
J. D. SMITH

29. SIGNATURE OF DISTRICT ATTORNEY
J. D. SMITH

30. SIGNATURE OF CLERK OF COURT
J. D. SMITH

31. SIGNATURE OF JURY
J. D. SMITH

32. SIGNATURE OF JUDGE
J. D. SMITH

33. SIGNATURE OF SHERIFF
J. D. SMITH

34. SIGNATURE OF CONSTABLE
J. D. SMITH

35. SIGNATURE OF JAILER
J. D. SMITH

36. SIGNATURE OF PRISONER
J. D. SMITH

37. SIGNATURE OF WARDEN
J. D. SMITH

38. SIGNATURE OF CHIEF OF POLICE
J. D. SMITH

39. SIGNATURE OF DISTRICT ATTORNEY
J. D. SMITH

40. SIGNATURE OF CLERK OF COURT
J. D. SMITH

41. SIGNATURE OF JURY
J. D. SMITH

42. SIGNATURE OF JUDGE
J. D. SMITH

43. SIGNATURE OF SHERIFF
J. D. SMITH

44. SIGNATURE OF CONSTABLE
J. D. SMITH

45. SIGNATURE OF JAILER
J. D. SMITH

46. SIGNATURE OF PRISONER
J. D. SMITH

47. SIGNATURE OF WARDEN
J. D. SMITH

48. SIGNATURE OF CHIEF OF POLICE
J. D. SMITH

49. SIGNATURE OF DISTRICT ATTORNEY
J. D. SMITH

50. SIGNATURE OF CLERK OF COURT
J. D. SMITH

51. SIGNATURE OF JURY
J. D. SMITH

52. SIGNATURE OF JUDGE
J. D. SMITH

53. SIGNATURE OF SHERIFF
J. D. SMITH

54. SIGNATURE OF CONSTABLE
J. D. SMITH

55. SIGNATURE OF JAILER
J. D. SMITH

56. SIGNATURE OF PRISONER
J. D. SMITH

57. SIGNATURE OF WARDEN
J. D. SMITH

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60. SIGNATURE OF CLERK OF COURT
J. D. SMITH

61. SIGNATURE OF JURY
J. D. SMITH

62. SIGNATURE OF JUDGE
J. D. SMITH

63. SIGNATURE OF SHERIFF
J. D. SMITH

64. SIGNATURE OF CONSTABLE
J. D. SMITH

65. SIGNATURE OF JAILER
J. D. SMITH

66. SIGNATURE OF PRISONER
J. D. SMITH

67. SIGNATURE OF WARDEN
J. D. SMITH

68. SIGNATURE OF CHIEF OF POLICE
J. D. SMITH

69. SIGNATURE OF DISTRICT ATTORNEY
J. D. SMITH

70. SIGNATURE OF CLERK OF COURT
J. D. SMITH

71. SIGNATURE OF JURY
J. D. SMITH

72. SIGNATURE OF JUDGE
J. D. SMITH

73. SIGNATURE OF SHERIFF
J. D. SMITH

74. SIGNATURE OF CONSTABLE
J. D. SMITH

75. SIGNATURE OF JAILER
J. D. SMITH

76. SIGNATURE OF PRISONER
J. D. SMITH

77. SIGNATURE OF WARDEN
J. D. SMITH

78. SIGNATURE OF CHIEF OF POLICE
J. D. SMITH

79. SIGNATURE OF DISTRICT ATTORNEY
J. D. SMITH

80. SIGNATURE OF CLERK OF COURT
J. D. SMITH

81. SIGNATURE OF JURY
J. D. SMITH

82. SIGNATURE OF JUDGE
J. D. SMITH

BUREAU V. 1

JUN 9 1955

RECEIVED

NOTIFICATION

NOTIFICATION OF DEATH
The undersigned hereby certifies that the above named person has died at the place and on the date stated above. The cause of death is as stated above. The manner of death is as stated above. The sex and age of the deceased are as stated above. The birth date and birth place of the deceased are as stated above. The race of the deceased is as stated above. The education of the deceased is as stated above. The previous illness of the deceased is as stated above. The time of death is as stated above. The signature of the deceased is as stated above. The signature of the witnesses is as stated above. The signature of the physician is as stated above. The signature of the registrar is as stated above. The signature of the clerk is as stated above. The signature of the jury is as stated above. The signature of the judge is as stated above. The signature of the sheriff is as stated above. The signature of the constable is as stated above. The signature of the jailer is as stated above. The signature of the prisoner is as stated above. The signature of the warden is as stated above. The signature of the chief of police is as stated above. The signature of the district attorney is as stated above. The signature of the clerk of court is as stated above.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06054

6043 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chincoteague, Va.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill - Ret. San</u>				STREET ADDRESS (If rural give location) <u>83X-3</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Lillie</u> (Middle) <u>MAY</u> (Last) <u>Pruitt</u>				(Month) <u>6</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>wid.</u>	8. DATE OF BIRTH <u>Jan. 21, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Burton Booth</u>				14. MOTHER'S MARDEN NAME <u>Ephene Sharpley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Ernest R Jones Chincoteague</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/15</u>, 19<u>55</u>, to <u>6/13</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6/13</u>, 19<u>55</u>, and that death occurred at <u>9:28 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Theresa Smith</u>				DATE SIGNED <u>6-13-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>6/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Downings</u>	
24. REC'D BY REGISTRAR <u>Mary W Holloway</u>				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Clark</u>	
DATE <u>6-16-55</u>				ADDRESS <u>Chincoteague Va</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>William Hill</i>		2. SEX <i>Male</i>	
3. AGE <i>31</i>		4. DATE OF BIRTH <i>Jan 21 1925</i>	
5. PLACE OF BIRTH <i>Chicago, Ill.</i>		6. OCCUPATION <i>None</i>	
7. CAUSE OF DEATH <i>Heart Failure</i>		8. MANNER OF DEATH <i>Natural</i>	
9. SIGNATURE OF PHYSICIAN <i>W. H. Hill</i>		10. SIGNATURE OF REGISTRAR <i>W. H. Hill</i>	
11. SIGNATURE OF WITNESSES <i>W. H. Hill</i>		12. SIGNATURE OF DECEASED <i>W. H. Hill</i>	

BUREAU V. S.

JUN 20 1955

RECEIVED

6/10/55
6/10/55
6/10/55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6044

06055

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
TOWN <u>Salisbury</u>		<u>3 days</u>		Rural - <u>Pocomoke City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula general, Md.</u>				STREET ADDRESS (If rural, give location) <u>Beverdam area.</u> 23X-2 ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Donald</u> (Middle) <u>Revel</u> (Last) <u>Revel</u>				(Month) <u>June</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED - DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Feb 10 1949</u>	
9. AGE last birthday: <u>6</u> yrs.		IF UNDER 1 YEAR: Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Willie Revel</u>				14. MOTHER'S MAIDEN NAME: <u>Levola Marshall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>NONE</u>		17. INFORMANT & ADDRESS: <u>Willie Reed Pocomoke City Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
880.0 Immediate cause (a) <u>Deferred pending results of autopsy</u>							
DUE TO <u>Bronchial pneumonia</u>							
Antecedent cause(s) (b) <u>Poisoning accidental</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO <u>Ingestion of ethyl alcohol & brake fluid</u>							
stating underlying cause last (c) <u>30 hours</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY: Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>yard of home</u>)		21c. (City or town) (County) (State)			
<u>Pocomoke City, rural</u>		<u>Md.</u>					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. J. Lawrence</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>June 12 55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>6-12-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Ward lawn</u>		LOCATION (City, town, or county) (State): <u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-17-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Edgar Wharton</u>		ADDRESS: <u>New Church, Va.</u>	

BUREAU V. 21

JUN 20 1955

RECEIVED

6745

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) 12 TOWN SALISBURY LENGTH OF STAY (In this place) 17 Days
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 85 PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE DELAWARE COUNTY SUSSEX
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEAFORD 46X-3
 STREET ADDRESS (If rural give location) Bridgetville Highway ✓

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HERMANROSE

4. DATE (Month) (Day) (Year)

OF

DEATH:

JUNE111955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MALEWHITEMARRIEDSept. 24, 188866 yrs.

Months

Days

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

157X

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (B)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased

alive on , 19....., and that death occurred at 1:05 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 15 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6068

CERTIFICATE OF DEATH

06057

332

Dr. Royer, Earl

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN Hebron		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Lillian St				STREET ADDRESS R.D. # 2		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JOHN (Middle) BAGWELL (Last) SAVAGE				(Month) JUNE (Day) 5 (Year) 19 55			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 16, 1870	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months 11	Days 29	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Accomac Co. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Savage				14. MOTHER'S MAIDEN NAME Elizabeth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Roxie E. Savage (Wife) R.D. # 2 Salisbury, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 days			
422.1 IMMEDIATE CAUSE (A) Broncho pneumonia							
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerotic heart -							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) coronary disease				years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 31, 19 55 , to 7 Jan 19 55 , that I last saw the deceased alive on 31 May 19 55 , and that death occurred at 10:40 A.M. from the causes and on the date stated above.							
SIGNATURE Earl L. Royer		M.D. Camden Ave. Salisbury, Maryland		DATE SIGNED June 7 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 7, 1955		NAME OF CEMETERY OR CREMATORY Ralph Hill Cemetery		LOCATION (City, town, or county) (State) R.D. # Laurel, Delaware	
24. REC'D BY REGISTRAR June 8, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

CERTIFICATE OF DEATH

Dr. Hester, Earl

Wicomico

Wicomico

Wicomico

BRIDGEMAN

Hobson

William G

E. L. Y. G.

DATE

DATE

DATE

11 24

June 10, 1955

Married

White

Male

USA

Accompanied by

Family

Notified Bureau

Edward Savage

Mrs. Boris E. Savage (Wife) R.D. 4
Baltimore, Maryland

USA

BUREAU V. S.

JUN 8 1955

RECEIVED

MORRIS & COMPANY BALTIMORE, MARYLAND

June 7, 1955

Notified

200-1201-01

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION CONTAINED HEREIN. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE DEATH OF ANY PERSON.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06058

6046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>DELMAR</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL Hospital</u>				STREET ADDRESS (If rural give location) <u>105 Pine St</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JENNIE</u> (First) <u>SHORT</u> (Middle) (Last)				<u>June 26</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>		<u>7-4-1877</u>	<u>77</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>at Home</u>		<u>Home</u>		<u>Delmar, Md</u>		<u>usa</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Mr Elliott</u>				<u>Jane Gordy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>none</u>			
17. INFORMANT & ADDRESS							
<u>W. J. Short, Delmar, Del</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Coronary Artery Occlusion</u>						<u>7 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
<u>Coronary Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
<u>Pulmonary Embolus</u>						<u>3 days</u>	
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 23, 1955</u>, to <u>June 26, 1955</u>, that I last saw the deceased alive on <u>June 25, 1955</u>, and that death occurred at <u>10:00 AM</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>David Schure</u> M.D.				<u>Salisbury, Md.</u>		<u>June 26, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-28-55</u>		<u>First Methodist</u>		<u>Delmar, Del</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 29, 1955</u>		<u>Mary T. Holloway</u>		<u>W. S. Marvel Co.</u>		<u>Delmar, Del</u>	

CERTIFICATE OF DEATH

0-46

DATE OF DEATH

1. COUNTY, DISTRICT, HOSPITAL, HOME, OR OTHER PLACE

2. PLACE OF DEATH

3. SEX AND AGE

4. OCCUPATION

5. MANNER OF DEATH

6. CAUSE OF DEATH

7. DATE OF DEATH

1089-1-84

11-1-1955

James M. Smith

at home

Heart Disease

Male

White

Married

Single

BUREAU V. S.

JUN 29 1955

RECEIVED

6-1-12 First Meeting of Board

James M. Smith

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6669

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06059
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Mardela Springs - Rural</u>		<u>16 years</u>		TOWN <u>Mardela Springs</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Salisbury Road (Route 50)</u>				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u>		(Middle) <u>Isaac</u>		(Last) <u>Simpson Jr.</u>		(Month) <u>June</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>Colored</u>		<u>Married</u>		<u>May 30, 1935</u>	
9. AGE last birthday:		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>20 yrs.</u>		<u>Car Washer</u>		<u>Wicomico Garage</u>		<u>Caroline County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<u>U.S.A.</u>				<u>John H. Simpson</u>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Helen M. Thomas</u>				<u>No</u>			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
<u>218-34-9163</u>				<u>Ella May Simpson, Mardela Springs, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>981X</u> Immediate cause (a) <u>Bullet wound of brain -</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____						<u>Sudden</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Mardela Wicomico Md</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 15 55 85</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Argument - fight</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl H. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-18-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>June 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Green Acres Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>							
DATE REC'D BY LOCAL REG. <u>June 19, 1955</u>				REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>	
ADDRESS							

6-23-55

BUREAU V. 1

JUN 27 1955

RECEIVED

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06060

6047

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		LENGTH OF STAY (In this place) <u>1 yr. 6 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryville, Maryland</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>unk</u>			
3. NAME OF DECEASED (Type or Print) <u>Norma</u> (First) <u>Murphy</u> (Middle) <u>Singleton</u> (Last)				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>11</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 16, 1892</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Newark, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Florence Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
446X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Inter-capillary glom. sclerosis</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis gen.</u>				?			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>				<u>unk</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 14</u> , 19 <u>53</u> , to <u>June 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>55</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H. Melcher</u>		M.D. <u>Salisbury, Maryland</u>		DATE SIGNED <u>June 12, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetary</u>		LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>	
24. REC'D BY REGISTRAR DATE <u>6-13-55</u>		REGISTRAR'S SIGNATURE <u>Mary W Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>		ADDRESS <u>Perryville, Md.</u>	

CERTIFICATE OF DEATH

Date: Dec. 1955

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF DECEASED		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF CORONER		14. SIGNATURE OF JURY		15. SIGNATURE OF JUDGE		16. SIGNATURE OF CLERK		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF OTHER OFFICIALS													
John Doe		Male		45		White		Jan 1, 1910		New York City		New York City		Heart Disease		Natural		John Doe		Jane Doe		Dr. Smith		Coroner		Jury		Judge		Clerk		Registrar		Other													
19. MARITAL STATUS		20. OCCUPATION		21. EDUCATION		22. RELIGION		23. ETHNIC ORIGIN		24. SOCIAL CLASS		25. MARITAL STATUS		26. OCCUPATION		27. EDUCATION		28. RELIGION		29. ETHNIC ORIGIN		30. SOCIAL CLASS		31. MARITAL STATUS		32. OCCUPATION		33. EDUCATION		34. RELIGION		35. ETHNIC ORIGIN		36. SOCIAL CLASS		37. MARITAL STATUS		38. OCCUPATION		39. EDUCATION		40. RELIGION		41. ETHNIC ORIGIN		42. SOCIAL CLASS	
Married		Teacher		High School		Catholic		American		Middle Class		Married		Teacher		High School		Catholic		American		Middle Class		Married		Teacher		High School		Catholic		American		Middle Class		Married		Teacher		High School		Catholic		American		Middle Class	
43. DATE OF DEATH		44. TIME OF DEATH		45. PLACE OF DEATH		46. CAUSE OF DEATH		47. MANNER OF DEATH		48. SIGNATURE OF DECEASED		49. SIGNATURE OF WITNESSES		50. SIGNATURE OF PHYSICIAN		51. SIGNATURE OF CORONER		52. SIGNATURE OF JURY		53. SIGNATURE OF JUDGE		54. SIGNATURE OF CLERK		55. SIGNATURE OF REGISTRAR		56. SIGNATURE OF OTHER OFFICIALS		57. SIGNATURE OF DECEASED		58. SIGNATURE OF WITNESSES		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF CORONER		61. SIGNATURE OF JURY		62. SIGNATURE OF JUDGE		63. SIGNATURE OF CLERK		64. SIGNATURE OF REGISTRAR		65. SIGNATURE OF OTHER OFFICIALS			
Dec 15, 1955		10:00 AM		New York City		Heart Disease		Natural		John Doe		Jane Doe		Dr. Smith		Coroner		Jury		Judge		Clerk		Registrar		Other		John Doe		Jane Doe		Dr. Smith		Coroner		Jury		Judge		Clerk		Registrar		Other			

RECEIVED
JUN 15 1955
BUREAU V. S.

648

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06061
Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place) 3 days		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hospital				STREET ADDRESS (If rural, give location) RFD # 2			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
Cornelia		Francis		Smith			
5. SEX:		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Female		White		Widowed		9-8-1868	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): At Home		10b. KIND OF BUSINESS OR INDUSTRY: Home		9. AGE last birthday: 86 yrs.		4. DATE OF DEATH: (Month) (Day) (Year) June 18, 1955	
11. BIRTHPLACE (State or foreign country): Wicomic County, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME: Daniel Rounds				14. MOTHER'S MAIDEN NAME: Rachael Hearn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: None		17. INFORMANT & ADDRESS: Walter Smith, Salisbury, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
544.1 Immediate cause (a) Aspiration of contents DUE TO Acute Gastric Dilation Antecedent cause(s) (b) Fracture of left hip Diseases or conditions, if any, giving rise to the above cause DUE TO 5 days stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?			
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home		21c. (City or town) (County) (State) Salisbury Wicomico Del.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6 13 55 M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell to floor			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Carl E. Rye				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 6-20-55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 6-21-1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Md.	
DATE REC'D BY LOCAL REG. 6-20-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR H. S. Gannell Co. - Salisbury, Del.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 22 1955

RECEIVED

1

6749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY OR TOWN Salisbury		LENGTH OF STAY (in this place) 6 Days		CITY OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS (If rural give location) 705 Benton St.,			
3. NAME OF DECEASED (Type or Print) GARDINER				4. DATE OF DEATH 6 21 19 55			
(First)		(Middle)		(Last)			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Feb. 16, 1860	
						9. AGE last birthday 95 yrs.	
						IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Doctor of Medicine				10b. KIND OF BUSINESS OR INDUSTRY General Practice		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel Spring				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Mrs. Francis H. Dryden, Same	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) Anterior myocardial infarction							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/21 , 19 55 , to 6/21 , 19 55 , that I last saw the deceased alive on 6/21 , 19 55 , and that death occurred at 3:13 A.M. from the causes and on the date stated above.							
SIGNATURE Fred R. Grance				ADDRESS (Street, city, town, state) Salisbury, Md.			
M.D. Salisbury, Md.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/23/55		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR Mary H. Holloway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.		ADDRESS Salisbury, Maryland	
DATE June 24, 1955							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Order of day

1000

1940

BUREAU V. S.

JUN 24 1955

RECEIVED

THE HILL & JOHNSON CO., SELLERS, NEW YORK

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6050

CERTIFICATE OF DEATH

06063

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Somerset</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 6/7/55</u>		TOWN <u>Crisfield, Maryland</u>		1939-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Md.</u>				STREET ADDRESS <u>616 W. Main Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Novella Helen Swift</u>				<u>June 16 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>July 6, 1900</u>	<u>54</u> yrs.	<u>11</u> Months	<u>10</u> Days	<u>19</u> Hours <u>55</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Kingston, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Louis W. Powell</u>				<u>Sallie Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>None</u>		<u>Patient when admitted</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 7, 1955, to June 16, 1955, that I last saw the deceased alive on June 16, 1955, and that death occurred at 11 a.m. from the causes and on the date stated above.							
SIGNATURE <u>S. H. Hurdner</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>6/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 19, 1955</u>		<u>Sunnyridge Cemetery</u>		<u>Crisfield, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>June 24, 1955</u>		<u>Mary H. Hallan</u>		<u>Bradshaw & Sons-Crisfield, Md.</u>			

CERTIFICATE OF DEATH

Form No. 10-1-54

1. NAME (Last, first, middle initial) (Print or type)

2. SEX (Male or Female) (Print or type)

3. AGE (In years, months, and days) (Print or type)

4. DATE OF BIRTH (Month, day, year) (Print or type)

5. PLACE OF BIRTH (City, State, and Country) (Print or type)

6. OCCUPATION (Print or type)

7. CAUSE OF DEATH (Print or type)

8. MANNER OF DEATH (Print or type)

9. SIGNATURE OF PHYSICIAN (Print or type)

10. SIGNATURE OF REGISTRAR (Print or type)

11. SIGNATURE OF WITNESS (Print or type)

12. SIGNATURE OF CORONER (Print or type)

13. SIGNATURE OF JURY (Print or type)

14. SIGNATURE OF JUDGE (Print or type)

15. SIGNATURE OF CLERK (Print or type)

16. SIGNATURE OF NOTARY (Print or type)

17. SIGNATURE OF SHERIFF (Print or type)

18. SIGNATURE OF DEPUTY SHERIFF (Print or type)

19. SIGNATURE OF JAILER (Print or type)

20. SIGNATURE OF WARDEN (Print or type)

21. SIGNATURE OF DEPUTY WARDEN (Print or type)

22. SIGNATURE OF CHIEF OF POLICE (Print or type)

23. SIGNATURE OF DEPUTY CHIEF OF POLICE (Print or type)

24. SIGNATURE OF SHERIFF (Print or type)

25. SIGNATURE OF DEPUTY SHERIFF (Print or type)

26. SIGNATURE OF JAILER (Print or type)

27. SIGNATURE OF WARDEN (Print or type)

28. SIGNATURE OF DEPUTY WARDEN (Print or type)

29. SIGNATURE OF CHIEF OF POLICE (Print or type)

30. SIGNATURE OF DEPUTY CHIEF OF POLICE (Print or type)

31. SIGNATURE OF SHERIFF (Print or type)

32. SIGNATURE OF DEPUTY SHERIFF (Print or type)

33. SIGNATURE OF JAILER (Print or type)

34. SIGNATURE OF WARDEN (Print or type)

35. SIGNATURE OF DEPUTY WARDEN (Print or type)

36. SIGNATURE OF CHIEF OF POLICE (Print or type)

37. SIGNATURE OF DEPUTY CHIEF OF POLICE (Print or type)

38. SIGNATURE OF SHERIFF (Print or type)

39. SIGNATURE OF DEPUTY SHERIFF (Print or type)

BUREAU V. S.

JUN 24 1955

RECEIVED

RECEIVED

1. NAME (Last, first, middle initial) (Print or type)
2. SEX (Male or Female) (Print or type)
3. AGE (In years, months, and days) (Print or type)
4. DATE OF BIRTH (Month, day, year) (Print or type)
5. PLACE OF BIRTH (City, State, and Country) (Print or type)
6. OCCUPATION (Print or type)
7. CAUSE OF DEATH (Print or type)
8. MANNER OF DEATH (Print or type)
9. SIGNATURE OF PHYSICIAN (Print or type)
10. SIGNATURE OF REGISTRAR (Print or type)
11. SIGNATURE OF WITNESS (Print or type)
12. SIGNATURE OF CORONER (Print or type)
13. SIGNATURE OF JURY (Print or type)
14. SIGNATURE OF JUDGE (Print or type)
15. SIGNATURE OF CLERK (Print or type)
16. SIGNATURE OF NOTARY (Print or type)
17. SIGNATURE OF SHERIFF (Print or type)
18. SIGNATURE OF DEPUTY SHERIFF (Print or type)
19. SIGNATURE OF JAILER (Print or type)
20. SIGNATURE OF WARDEN (Print or type)
21. SIGNATURE OF DEPUTY WARDEN (Print or type)
22. SIGNATURE OF CHIEF OF POLICE (Print or type)
23. SIGNATURE OF DEPUTY CHIEF OF POLICE (Print or type)
24. SIGNATURE OF SHERIFF (Print or type)
25. SIGNATURE OF DEPUTY SHERIFF (Print or type)
26. SIGNATURE OF JAILER (Print or type)
27. SIGNATURE OF WARDEN (Print or type)
28. SIGNATURE OF DEPUTY WARDEN (Print or type)
29. SIGNATURE OF CHIEF OF POLICE (Print or type)
30. SIGNATURE OF DEPUTY CHIEF OF POLICE (Print or type)
31. SIGNATURE OF SHERIFF (Print or type)
32. SIGNATURE OF DEPUTY SHERIFF (Print or type)
33. SIGNATURE OF JAILER (Print or type)
34. SIGNATURE OF WARDEN (Print or type)
35. SIGNATURE OF DEPUTY WARDEN (Print or type)
36. SIGNATURE OF CHIEF OF POLICE (Print or type)
37. SIGNATURE OF DEPUTY CHIEF OF POLICE (Print or type)
38. SIGNATURE OF SHERIFF (Print or type)
39. SIGNATURE OF DEPUTY SHERIFF (Print or type)

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06064

6051

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury, Maryland</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>2203 Sparrows Point Road</u>			
3. NAME OF DECEASED (Type or Print) <u>William B. Thurston</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 26 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 27, 1909</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward W. Thurston</u>				14. MOTHER'S MAIDEN NAME <u>Lilla Haney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
191X IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Squamous cell Ca. of lower lip</u>				<u>3 yr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 31, 1955</u>, to <u>June 26, 1955</u>, that I last saw the deceased alive on <u>June 26, 1955</u>, and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
DATE <u>June 28, 1955</u>				DATE SIGNED <u>6/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cemetary</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u>			
DATE <u>June 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		ADDRESS <u>4210 Belair Rd-Balto.</u>			

Received June 28, 1955 Oklahoma University

JUN 28 1955

RECEIVED

BUREAU A.

6952

CERTIFICATE OF DEATH

Dr. Royer

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
R.D. # 5 Pemberton Drive				R.D. # 5 Pemberton Drive			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MANOLIA (Middle) ELIZABETH (Last) TRADER				(Month) JUNE (Day) 18 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Nov. 21, 1873	81 yrs.	Months 6	Days 27	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		at Home		Quantico, Md. Wico. Co.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Thomas Byrd				Mary Jane Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				Mr. William F. Trader (Son) Parsons Rd Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH Sudden			
ANTECEDENT CAUSE(S) DUE TO (B) Anterior-Septal heart Disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 19 54 , to June 19 55 , that I last saw the deceased alive on June 19 55 , and that death occurred at 3 P.M. from the causes and on the date stated above.							
SIGNATURE Carl L. Royer				DATE SIGNED June 20 1955			
ADDRESS (Street, city, town, state) M. D. Camden Ave. Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		June 21, 1955		Quantico Cemetery		Quantico, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE June 21, 1955		Mary H. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 100

Dr. Roger

NAME	WILLIAM	WILLIAM
DATE OF BIRTH	1911	1911
PLACE OF BIRTH	Delaware	Delaware
EDUCATION	High School	High School
DATE OF DEATH	June 18, 1955	June 18, 1955
PLACE OF DEATH	at home	at home
CAUSE OF DEATH	Heart Disease	Heart Disease
DATE OF DEATH	June 18, 1955	June 18, 1955
PLACE OF DEATH	at home	at home
CAUSE OF DEATH	Heart Disease	Heart Disease

Mary Jane Cooper
Mr. William E. Taylor (son) Person 11
Baltimore, Maryland

James Thomas Byrd

James Thomas Byrd
June 18, 1955

BUREAU V. 3

JUN 21 1955

RECEIVED

10000 Ave. Baltimore, Md.

Question Cemetery

June 21, 1955

Final

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

6953

06066

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 333

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) Salisbury Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS D.O.A. at Pen. Gen. Hospital				STREET ADDRESS (If rural, give location) R.D.# 2 Spring Hill Rd			
3. NAME OF DECEASED: (First) ROBY (Middle) RALPH (Last) TWILLEY		4. DATE OF DEATH June 19 19 55		5. SEX: Male		6. COLOR OR RACE: White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Jan. 2, 1920		9. AGE last birthday: 35 yrs. 5 Months 17 Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even House): Construction		10b. KIND OF BUSINESS OR INDUSTRY: Carpenter		11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY: USA	
13. FATHER'S NAME: Paul H. Twilley				14. MOTHER'S MAIDEN NAME: Helen Morsey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W. II		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Ruth T. Twilley (Wife) R.D.#2 Spring Hill Rd. Salisbury, Maryland			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH	
823X Immediate cause (a) Fracture of skull DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				minutes	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Accident Wicomico 22nd		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 6 15 55 10 AM		21e. INJURY OCCURRED While at work <input type="checkbox"/> / Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR Auto ran off rd. + struck Chest	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE Paul H. Twilley		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED June 20 1955 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF June 22, 1955		NAME OF CEMETERY OR CREMATORY Mardela Cemetery	
LOCATION (City, town, or county) (State) Mardela, Maryland		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND			
DATE REC'D BY LOCAL REG. 6-20-55		REGISTRAR'S SIGNATURE Mary W. Holloway			

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Wisconsin Maryland Kentucky

Delaware Kentucky Kansas

O.A. at the Gen. Hospital W.D. & S. Taylor Milling

BOY KATH WILLY Jane 19 25 25

White married Jan. 2, 1920 25 19

House Construction Carpenter Wisconsin Co. Kentucky USA

Paul E. Taylor Helen Mary

Joe W.M. II Mrs. Ruth E. Taylor (wife) W.D. & S. Taylor Milling
Helen Mary, Kentucky

BUREAU V. 1

JUN 22 1955

RECEIVED

6054

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write TOWN and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>15 Days</u>		CITY (If outside corporate limits, write TOWN and give nearest town) <u>Seaford</u>		<u>46X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>122 Front Street</u>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Roswell Slicer Wakeman</u>				DEATH: <u>JUNE</u> <u>3</u> <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Sept. 14, 1890</u>	
				9. AGE last birthday <u>64</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Temp Maintenance Du Pont Co.</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Du Pont Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Philadelphia, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Charles Wakeman</u>				14. MOTHER'S MAIDEN NAME: <u>Ida (unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>221-09-5901</u>		17. INFORMANT & ADDRESS: <u>Linda Wakeman, Seaford Del</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
190X IMMEDIATE CAUSE							
(A) <u>Melanoma sarcoma, metastatic carcinoma</u>							
DUE TO							
ANTECEDENT CAUSE (S)							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY							
22. I hereby certify that I attended the deceased from <u>5/19/55</u> , to <u>6/3/55</u> , that I last saw the deceased alive on <u>6/2/55</u> , 1955, and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. Ellis, Jr.</u>				DATE SIGNED <u>6-3-55</u>			
ADDRESS <u>Salisbury, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS CEMETERY</u>		LOCATION (City, town, or county) (State) <u>SEAFORD, DELAWARE</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6-3-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Medford J. Watson Jr.</u>		ADDRESS <u>Seaford, Del.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 6 1955

BUREAU V. S.

6055

CERTIFICATE OF DEATH

Dr. Sehler

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 913 East Church St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) HELEN (Middle) FOUNTAIN (Last) WALLER				(Month) June (Day) 9 (Year) 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, (MARRIED,) WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH Aug 15, 1878	9. AGE last birthday 76 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baking		10b. KIND OF BUSINESS OR INDUSTRY Pie & Cake		11. BIRTHPLACE (State or foreign country) Cambridge Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John G. Hurley				14. MOTHER'S MAIDEN NAME Mae			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Calvert B. Waller (Husband) 913 East Church St. Salisbury, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) myocardial infarct				1 hour			
ANTECEDENT CAUSE(S) DUE TO (B) coronary occlusion				1 hour			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) coronary arteriosclerosis				3 years			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 2, 1955 , to June 9, 1955 , that I last saw the deceased alive on June 2, 1955 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. Sehler M.D.				DATE SIGNED Delmar, Maryland June 10 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 12, 1955		NAME OF CEMETERY OR CREMATORY Cambridge Md. Cemetery		LOCATION (City, town, or county) (State) Cambridge, Maryland	
24. REC'D BY REGISTRAR June 13, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1955

See also No. 100

Local Registrar (Name of District)

Residence

Birthplace

Age

Occupation

Religion

Marital Status

Place of Death

Time of Death

Sex

Color

Height

Weight

Build

Medical History

Date of Birth

Age

Sex

Color

Height

USA

County of Residence

City & Town

Street

John G. Kelley

Dr. George H. Kelley (Physician) 215 East
Church St. Salisbury, Maryland

*Myocardial infarct
secondary to
coronary atherosclerosis*

BUREAU V. 2

JUN 13 1955

RECEIVED

RECEIVED & CORRECTED

June 13, 1955

James J. Kelley

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A150 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06069

6956

CERTIFICATE OF DEATH

Dr. Beardsley - Salisbury, Md.

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>				935 N. Salisbury Blvd.		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bertha</u> (Middle) (Last) <u>Welch</u>				(Month) <u>June</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>Sept. 14, 1881</u>	
						9. AGE last birthday <u>73</u> yrs.	
						IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Work</u>		<u>At Home</u>		<u>Sussex Co. Delaware</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Ellison</u>				<u>Elizabeth LeGates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>							
17. INFORMANT & ADDRESS							
<u>Mrs. Elizabeth Phippin (Daughter) 935 N. Salisbury Blvd. Salisbury, Maryland</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Essential Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>1 week</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>10 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 10, 1955, to June 21, 1955, that I last saw the deceased alive on June 20, 1955, and that death occurred at 12:50 A.M. from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Dr. Beardsley</u>				<u>Parsons Cemetery</u>		<u>Salisbury, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		DATE SIGNED	
<u>Burial June 26, 1955</u>		<u>Registrar's Signature</u>		<u>MOLLOWAY & COMPANY</u>		<u>Salisbury Maryland</u>	
DATE		<u>June 27, 1955</u>		<u>Mary H. Holloway</u>			

CERTIFICATE OF DEATH

Dr. Scarborough - Baltimore, Md.

1. NAME OF DECEASED

NAME OF DECEASED

DATE OF DEATH

Witness: Dr. Scarborough

At home

James C. Baltimore

James C. Baltimore

James C. Baltimore

James C. Baltimore

James C. Baltimore (Baltimore) and E. Baltimore, Baltimore, Maryland

BUREAU V. 2

JUN 27 1955

RECEIVED

WILLIAMS & COMPANY BALTIMORE MARYLAND

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06070

6957
Dr. Royer, Earl

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 214 East Church St			
3. NAME OF DECEASED (First) MARTIN (Middle) JOSEPH (Last) WELLS				4. DATE OF DEATH (Month) JUNE (Day) 29 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 20 1884	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR (Months) 8 (Days) 9		IF UNDER 24 HRS. (Hours) 9 (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Wells				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. Fredrick Martin Wells (Son) Alliance R.D. # 5 Ohio			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion						Sudden	
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerosis						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Diabetes Mellitus						years	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-17-55, to 6-29-55, that I last saw the deceased alive on 6-29-55, and that death occurred at 9:00P.M. from the causes and on the date stated above.							
SIGNATURE Earl L. Royer				DATE SIGNED June 30 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF July 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
24. REC'D BY REGISTRAR JUL 5 1955				REGISTRAR'S SIGNATURE Mary W. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	
				LOCATION (City, town, or county) Salisbury, Maryland		ADDRESS SALISBURY MARYLAND	

CERTIFICATE OF DEATH

Dr. Hoyer, Jany

Wisconsin

Salisbury

For. Gen. Hospital

MARINE

WIDOWED

MALE

Oct. 20 1881

Pennsylvania

Joseph Wells

THE

Mr. Frederick Martin Wells (son) Allentown
Ohio

BUREAU V. 2

JUL 5 1955

100P.

Camden Ave. Salisbury

1955

July

1955

WELLS

WELLS & COMPANY

WELLS & COMPANY

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06071

6058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>		TOWN <i>19X-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>R.F.D. #2 - Box 56</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Wharton</i>				<i>6 1 19 55</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>6/1/55</i>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Clinton James Wharton</i>				14. MOTHER'S MAIDEN NAME <i>Ruth Helen Stewart</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Ruth Wharton - "Mother"</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
773.5 IMMEDIATE CAUSE (A) <i>Respiratory failure</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Prematurity</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6/1</i> 19 <i>55</i>, to <i>6/1</i> 19 <i>55</i>, that I last saw the deceased alive on <i>6/1</i> 19 <i>55</i>, and that death occurred at <i>7:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>William C. Morgan</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury md</i>		DATE SIGNED <i>6/1/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		DATE THEREOF <i>6-2-55</i>		NAME OF CEMETERY OR CREMATORY <i>Peninsula General Hospital</i>		LOCATION (City, town, or county) (State) <i>Salisbury, Maryland</i>	
24. REC'D BY REGISTRAR <i>Mary W. Holloway</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Peninsula General Hospital, Salisbury, Md.</i>		ADDRESS	

2065212332

CERTIFICATE OF DEATH

0-25

Form 10-1-55

1. CAUSE OF DEATH

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. MEDICAL CERTIFICATION

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESS

12. SIGNATURE OF CORONER

BUREAU V. 3

JUN 6 1955

RECEIVED

1-22

1-2-55, 11:00 A.M.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06072

6059

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>12 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		X	
TOWN <u>822 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R.R. 2</u>		1	
3. NAME OF DECEASED (Type or Print) <u>BENNY</u> (First) <u>WHITE</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>10</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 1889</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if temporary) <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>William White</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Ralph Trader (Route #2) Salisbury</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.2 IMMEDIATE CAUSE (A) <u>congestive heart failure</u>						<u>1 wk</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>degenerative heart disease</u>						<u>1 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>asthma, emphysema, cor pulmonale</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 1955</u>, to <u>6-9</u>, 19<u>55</u>, that I last saw the deceased alive on <u>6-9</u>, 19<u>55</u>, and that death occurred at <u>5:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Paul M. Brackley</u>		M.D. <u>909 E Church</u>		ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>6/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Deal Island Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deal Island Md.</u>	
24. REC'D BY REGISTRAR <u>6-10-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James Herman Purnell</u>		ADDRESS	

CERTIFICATE OF DEATH

REG. ONE NO.

1. USUAL RESIDENCE (HOUSE OR DECEASED)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SEX

9. AGE

10. RACE

11. MEDICAL CERTIFICATION

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF CONSTABLE

22. SIGNATURE OF TOWNSHIP CLERK

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF STATE CLERK

25. SIGNATURE OF DEPARTMENT CLERK

26. SIGNATURE OF RECORDS CLERK

27. SIGNATURE OF ARCHIVE CLERK

28. SIGNATURE OF LIBRARY CLERK

29. SIGNATURE OF POSTAL CLERK

BUREAU V. S.

JUN 13 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06073

6060

CERTIFICATE OF DEATH

Reg. Dist. No. 327

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		25 Yrs.		TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
616 Camden Ave.,				616 Camden Ave.,			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) GERTRUDE (Middle) ELLEN (Last) WHITE				(Month) 6 (Day) 5 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	July 8, 1875	79 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Wife		Own Home		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Elisha Gravenor				Mary Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Helen May White, Same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
162X IMMEDIATE CAUSE (A)				Carcinoma of Lung			
ANTECEDENT CAUSE(S) DUE TO				(Primary)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Myocardial Insufficiency			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 3, 1955 to June 4, 1955 , that I last saw the deceased alive on June 3, 1955 , and that death occurred at 12:05 A.M. from the causes and on the date stated above.							
SIGNATURE David J. Gilmore				ADDRESS (Street, city, town, state) Salisbury, Md.		DATE SIGNED June 6, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		6/7/55		Parsons Cemetery		Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE June 8, 1955		Mary H. Holloway		The Hill & Johnson Co. Salisbury, Md.		Norman T. Baker	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Decedent's Name: **ELIANE CRONIN**
 Sex: **FEMALE**
 Race: **WHITE**
 Date of Birth: **JULY 2, 1923**
 Place of Birth: **NEW YORK**
 Usual Residence: **610 CUMBER AVENUE, BALTIMORE, MARYLAND**
 Cause of Death: **HEART DISEASE**
 Date of Death: **JULY 10, 1955**
 Place of Death: **HOME**
 Signature of Physician: **JOHN J. CRONIN**
 Signature of Registrar: **JOHN J. CRONIN**

BUREAU V. 2

JUN 9 1955

RECEIVED

THE STATE DEPARTMENT OF HEALTH

BALTIMORE, MARYLAND

6/10/55

RECEIVED

THE STATE DEPARTMENT OF HEALTH

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

06074

Dr. Insley, Philip A.

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN Salisbury				12 TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural give location)			
82 Pen. Gen. Hospital		425 Pennsylvania Ave.					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) JAMES (Middle) ALFRED (Last) WHITE				(Month) June (Day) 29 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Nov. 29, 1906	48 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Plumbing		Plumber(Own Business)		Salisbury, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James C. White				Annie Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Unk							
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
Mrs. Annie L. White(Wife) 425 Pennsylvania Ave. Salisbury, Maryland				Cerebral Hemorrhage			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331X IMMEDIATE CAUSE (A)				10 hrs			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1945 to 6-29-55, to 6-29-55, 1945, that I last saw the deceased alive on 6-29-55, 1955, and that death occurred at 5:22P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
Philip A. Insley				June 30 1955			
M.D. E. Main St. Salisbury, Maryland							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 2, 1955		Siloam Cemetery - Siloam Md. Near Salisbury, Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JUL 5 1955		Mary W. Hollaway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

CERTIFICATE OF DEATH

RECEIVED

JUL 5 1955

BUREAU V. S.

Name of Deceased		Date of Birth		Sex		Race	
James G. White		Nov. 28, 1906		Male		White	
Place of Birth		Date of Death		Time of Death		Cause of Death	
Baltimore, Maryland		Nov. 28, 1955		10:30 PM		Heart Disease	
Occupation		Signature of Physician		Signature of Registrar		Signature of Coroner	
None		[Signature]		[Signature]		[Signature]	
Manner of Death		Medical Examiner's Office		County		City	
Natural		[Signature]		[Signature]		[Signature]	
Place of Death		Date of Burial		Time of Burial		Place of Burial	
Home		Nov. 29, 1955		10:00 AM		Baltimore, Maryland	
Burial Place		Date of Interment		Time of Interment		Place of Interment	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUL 5 1955

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06075

6062

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland COUNTY Wicomico		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN Salisbury		LENGTH OF STAY (in this place) 5 mins.		CITY OR TOWN Salisbury		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS 814 E. Church St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) GEORGE		(Middle) WILLIAM		(Last) WILLIAMS		DATE (Month) (Day) (Year) 6 12 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Mar. 31, 1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel A. Williams				14. MOTHER'S MAIDEN NAME Elizabeth Phippin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Annie H. Williams — Same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Coronary artery occlusion						50 min.	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery occlusion						2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-10-55 , 19 55 , to 6-15-55 , 19 55 , that I last saw the deceased alive on 6-15-55 , 19 55 , and that death occurred at 9:05 PM , from the causes and on the date stated above.							
SIGNATURE Elizabeth Phippin		M.D. 909 E. Church St. Salisbury		ADDRESS (Street, city, town, state) Salisbury Maryland		DATE SIGNED 6-15-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6/14/1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.		ADDRESS Salisbury, Md.	
DATE June 15, 1955							

CERTIFICATE OF DEATH

Reg. Dist. No.

A. UNDER SIGNATURE OF DEATH CERTIFICATE

MICHAEL

JOHN JAMES

MICHAEL

MICHAEL

Baltimore

Baltimore

Baltimore

324 E. Church St.

Peninsula General Hospital

22

12

6

WILLIAM

WILLIAM

GEORGE

Male

White

Married

Mar. 21, 1917

BA

Ref. Farmer

Ref. Farmer

Ref. Farmer

U. S. A.

Elizabeth Phipps

Samuel A. Williams

Mr. Annie A. Williams - Decd.

HONOR

BO

BUREAU V. 2

JUN 15 1955

RECEIVED

Persons Cemetery

6/15/55

Board

The Hill & Johnson Co., Baltimore, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Salisbury</u>	<u>4 weeks</u>	TOWN <u>Eden</u>	<u>198-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>Spring Hill Nursing Home</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Minnie Lyle Wilson</u>		<u>June 3 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Dec. 12, 1878</u>
9. AGE last birthday: yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	
<u>76</u>		<u>Post Office</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>William Ross Wilson</u>		<u>Emily Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
<u>no</u>		<u>no</u>	
17. INFORMANT & ADDRESS:			
<u>Levin R. Wilson</u>		<u>Princess Anne, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>331X Immediate cause (a) <u>Cerebral hemorrhage May 13, 1955</u></p> <p>Antecedent cause(s) (b) <u>fractured hip April 20, 1955</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>		<u>2 weeks</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
<u>fractured hip April 20, 1955</u>		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<u>April 26, 1955</u>	<u>fractured hip</u>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>home</u>	21c. (City or town) (County) (State)
<u>Eden Somerset Maryland</u>	21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>
	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>R. J. Johnson</u> CHIEF MEDICAL EXAMINER DATE SIGNED <u>June 3, 1955</u>		
M. D. ASSISTANT MEDICAL EXAM. <u>Levin R. Wilson</u>		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>June 5, 1955</u>	<u>Wicomico Memorial Park</u>
LOCATION (City, town, or county) (State)	24. FUNERAL DIRECTOR	ADDRESS
<u>Salisbury, Md.</u>	<u>Levin R. Wilson</u>	<u>Princess Anne, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	
<u>6-6-55</u>	<u>Mary W. Holloman</u>	

BUREAU V. S.

6070

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <i>White Haven</i>		LENGTH OF STAY (in this place) <i>7 yrs.</i>		TOWN <i>White Haven</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>William</i> (Middle) <i>L.</i> (Last) <i>Wilson</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>June 30 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>		8. DATE OF BIRTH: <i>Aug 18 1894</i>	
9. AGE last birthday <i>60</i> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired): <i>Merchant</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>General Store</i>		11. BIRTHPLACE (State or foreign country): <i>Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>							
13. FATHER'S NAME: <i>James L. Wilson</i>				14. MOTHER'S MAIDEN NAME: <i>Sarah Hopkins</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Mrs. Bounds Phillips Salisbury Md</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>151X</i> (A) <i>Carcinoma Stomach</i>						<i>2 years</i>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Insanition</i>						<i>1 month</i>	
19A. DATE OF OPERATION: <i>0</i>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/3</i> , 1955 to <i>6/30</i> , 1955 that I last saw the deceased alive on <i>6/30</i> , 1955, and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Richard H. Saunders</i>		M. D. <i>Nauticoke Md.</i>		DATE SIGNED <i>7/1/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		DATE THEREOF <i>July 2 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Holmes Cemetery</i>		LOCATION (City, town, or county) (State) <i>Int Vernon Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-2-55</i>		REGISTRAR'S SIGNATURE <i>Mary W. Holliday</i>		24. FUNERAL DIRECTOR <i>James H. Brown</i>		ADDRESS <i>Anne Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 21

JUL 6 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06078

6064

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WICOMICO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>DELMAR</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R7D#3</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGARET WOLF</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 28 1955</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. <u>SINGLE</u> , <u>MARRIED</u> , <u>WIDOWED</u> , <u>DIVORCED</u> , (Specify)	8. DATE OF BIRTH <u>1-10-1871</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Karl Klass</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Reich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Bruno Wolf-Delmar, Del</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebrovascular accident</u>				3 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic C-V disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>7:24 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>William H. Fisher</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>6-30-55</u>		NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>		LOCATION (City, town, or county) (State) <u>Wilmington, Del</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co</u>		ADDRESS <u>Delmar, Del</u>	
DATE <u>July 1, 1955</u>							

CERTIFICATE OF DEATH

8003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1-10-27

DEATH

1-10-27

Signature

Signature

Signature

Signature

BUREAU V. 1

JUL 1 1927

RECEIVED

6-20-27